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November 29, 2013

Connecticut Office of the Healthcare Advocate
Hartford, Connecticut

Attention: Victoria Veltri, Healthcare Advocate

sim@ct.gov

COMMENTS TO PROPOSED STATE INNOVATION MODEL PLAN DRAFT 1.1

Connecticut Legal Services, Inc. (CLS) is the largest provider of high quality civil legal services to poor people in Connecticut. Our mission is to provide access to justice as a means of improving the lives of low-income people. Since its inception, CLS has worked hard to provide healthcare access to the residents of Connecticut, believing that appropriate healthcare is inherent in attaining the highest quality of life. Consistent with our mission and this core belief, we submit these comments for the Steering Committee's consideration.

Our strategic approach to advocacy is multidimensional, as we recognize that appropriate care is defined differently for each individual. Accordingly, we have broadened our advocacy to include health equity, as many of our clients have been disparately impacted because of their race, ethnicity and/or socioeconomic status. We are very pleased to see that the elimination of health disparities is a goal of the State Innovation Model (SIM) and that this goal is the driving force behind many of the initiatives in the plan.

As stated in the plan, the person centered medical home has been piloted here in Connecticut and has been shown to be an effective model in addressing racial and ethnic health disparities. We agree that this model should be held out as an ideal and expanded throughout the state. It has great potential to provide increased access to our clients and improve outcomes.

The nutritional incentive pilots are also an exciting opportunity to address several social determinants of health. Both heart disease and diabetes plague the African American and Latino community along with several cancers affected by diet. Introducing a nutritional incentive programs into the SNAP program has the potential to impact these populations tremendously, as smoking cessation incentive programs have done. We represent hundreds of SNAP recipients each year and are expanding our own work in food policy as we recognize the important role nutrition plays in our healthcare. We are very pleased this component is a part of the SIM draft.

The community health worker certification program will improve the patient provider relationship and reduce medical error and increase well visits and patient compliance. There is impressive work being done at UCONN on workforce development by a fellow Commissioner of mine who sits on the Commission of Health Equity. In addition, the Regional Health Equity Council for our region has done a tremendous amount of work on Community Health Workers and I would encourage the Steering Committee to contact them if additional information is needed and I would be happy to provide additional information.

Both the diabetes prevention program and the asthma home assessment programs have a documented history of effectiveness. Implementation and expansion will reduce existing gaps in the African American and Latino populations, where these conditions have a much higher incidence.[1,2] In addition, the incidence of avoidable hospitalizations attributed to asthma and emergency department visits attributed to asthma are higher in these two populations.[3] Critical to the success of these programs, is ensuring that these programs are covered services. Often a barrier to both diabetes prevention and asthma education is the lack reimbursement for these educational and preventative services for the providers and this barrier likely contributes to the increase mismanagement of each condition. Asthma morbidity rates and diabetes mortality rates are highest amongst this population, which, as your plan includes a subset of some of our poorest and least educated residents.[4] Socioeconomic factors are shown to have a negative impact on outcomes for both conditions compounding the issue even further. [5] There should be no out of pocket costs for the recipients and if there can be an incentive, even better. Diabetes prevention services are best done in a community based location or in the home so that they are easily accessed by those who need them- not in a clinical setting- as they teach lifestyle changes such as, diet changes, exercise, smoking cessation, etc.

We are pleased to see that consumer input has become an integral part of the plan going forward and that two consumer advocates have been recently added to the steering committee, in particular, Jane McNichol, Executive Director from the Legal Assistance Resource Center of Connecticut. We hope that the process will allow for meaningful input from consumers and their advocates, as this will truly enrich the process and the end product.

We continue to be concerned about the shared saving payment model, as we expressed in the letter we signed on to with our fellow advocates previously. We are relieved to see that Medicaid recipients will not be included in shared risk in the early phases; this could cause additional barriers to access for a population that is already attempting to overcome barriers to access by providing a disincentive to providers to refer patients. The rationale that is cited for the decision not to include the Medicaid program is intuitively correct: to avoid negative quality outcomes for program participants and unintended contraction of the Medicaid provider network.

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[1] Peng, J. and Nepaul A.N. (2013). *Asthma Data Brief - Comparison of Hospital Healthcare Utilization across Selected Geographic Designations*. Hartford, CT: Connecticut Department of Public Health.
[2] Stephanie M. Poulin, MPH, MT(ASCP) and Margaret M. Hynes, PhD, MPH (2010). *The Burden of Diabetes in Connecticut*. Hartford, CT: Connecticut Department of Public Health.
[3] Ibid.
[4] Ibid.
[5] Ibid.

The proposed solution to address this anticipated issue is a good start: The plan sets out to design quality metrics that will detect provider billing practices that seek savings through inappropriate methods, including reducing necessary access, adverse risk selection, lowering quality of care, cost shifting, withholding appropriate care or inappropriate referral practices for target conditions. In addition the plan indicates that there will be an effort made to prevent more systemic efforts to under-serve, particularly for uncommon conditions, or any conditions that are outside the scope of quality improvement metrics by establishing an Equity, Access and Appropriateness Council, comprised of consumer advocates, payer-based experts in audits and advanced analytic, and clinical experts and researchers from the state's academic health centers. This Council plans to recommend an audit strategy and methods that will guard against these risks and encourage payers to adopt such methods on or before implementation. My recommendation is this: Central to the SIM Plan is its goal to achieve the *elimination of health disparities for all of our residents.* If this is to be achieved, then this payment model should **not** be applied to the Medicaid population until the Council has devised a methodology that *ensures* the provider risk does not impact the Medicaid population's access to care. That cannot be ensured until the methodology has been developed and tested and found to be highly accurate with an extremely low error rate. This rate should be determined by an ad hoc committee of stakeholders with expertise on the Medicaid population and health equity access policy. The ad hoc committee can work with the Council to determine an acceptable rate that will not further hamper access. Unless it is done this way, the vision for the plan will fail and we want it to succeed.

Overall, our response to the plan is very positive. We believe that it is a very ambitious plan and hope that it can be achieved. We recognize that the plan looks to leverage existing resources with grant dollars and we hope that with proper coordination and prioritization the plan will be a success. We strongly urge the steering committee to allow for **meaningful** consumer and consumer advocate input throughout the remainder of the planning process. Further, we strongly urge the steering committee to **not** apply the shared savings/downside risk model to the Medicaid program and that it only consider applying this model to the Medicaid program once a methodology for detecting provider practices, as described above, has been developed and tested with a proven accuracy rate of an amount acceptable to an ad hoc committee of stakeholders.

Respectfully Submitted,

/s/Kristen Noelle Hatcher
Kristen Noelle Hatcher